

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 3021 STELLA DRIVE GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
R000000	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: February 18, 19, & 20, 2014</p> <p>Facility number: 012938 Provider number: 012938 AIM number: N/A</p> <p>Survey team: Patti Allen, SW-TC Marcy Smith, RN</p> <p>Census bed type Residential: 24 Total: 24</p> <p>Census payor type: Other: 24 Total: 24</p> <p>Residential sample: 6</p> <p>These state residential findings are cited accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 28, 2014; by Kimberly Perigo, RN.</p>		R000000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 3021 STELLA DRIVE GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure one staff with a current First Aide Certificate was on site in the facility at all times. This had the potential to affect 24 of 24 residents. (CNA #12, CNA #13, CNA #22, QMA #23, LPN #14, and LPN #24)</p> <p>Findings include:</p> <p>Review of the personnel files on 2/19/14</p>	R000117	<p><u>R 117 Personnel Deficiency</u> Corrective Action Taken: · The Director has reviewed and audited all personnel files to ensure CPR/First Aid training is current. · RNC scheduled CPR /First Aid classes with an outside vendor for current staff. · All staff attended the scheduled class and are currently certified. Potential Residents Affected: All residents had the potential to be affected, however no resident was negatively impacted by the</p>		03/07/2014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 3021 STELLA DRIVE GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>at AT 1:30 p.m. indicated six (6) of ten (10) employee files reviewed lacked documentation of First Aid Certification.</p> <p>Employee #12-CNA, Start date: 1/23/14, lacked documentation of First Aid Certification.</p> <p>Employee #13-CNA, Start date: 10/25/13, lacked documentation of First Aid Certification.</p> <p>Employee #14-LPN, Start date: 10/25/14, lacked documentation of First Aid Certification.</p> <p>Employee #22-CNA, Start date 1/29/14, lacked documentation of First Aid Certification.</p> <p>Employee #23-QMA, Start date 1/08/14, lacked documentation of First Aid Certification.</p> <p>Employee #24-LPN, Start date 11/19/13, lacked documentation of First Aid Certification.</p> <p>Review of the "Two Week as Worked Schedule" from the week of 2/9/14 to 2/22/14 indicated that on 2/9/14, 2/11/14, 2/12/14, 2/18/14, and 2/19/14, a staff person with First Aid Certification was not scheduled to be on-site for the night shift and on 2/15/14 and 2/16/14 for the day shift.</p> <p>The as worked schedule dated February</p>		<p>deficient practice. Measures to Ensure does not Recur: · All new employees are to have current CPR and First Aid upon hire. · Bickford to provide re-certification classes as necessary to maintain proper certification of staff. · Divisional Director of Operations to review on-boarding process with Director. · Director to be retrained on proper use of Orientation Checklist for documentation of that training.</p> <p>Monitor performance to ensure compliance as follows: Divisional Director of Operations to audit personnel files twice a year to ensure compliance using QA Audit (Core Check) document. Date of Compliance: 3/7/2014</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 3021 STELLA DRIVE GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>9 to 22, 2014 indicated:</p> <p>On 2/9/14 night shift 11:ppm.-7:00 a.m., Employee #22-CNA and Employee #15-CNA were only two (2) staff on the schedule, both lacked documentation of First Aid Certification.</p> <p>On 2/11/14 night shift 11:00 p.m.-7:00 a.m., Employee #24-LPN, Employee #15-CNA, Employee #25-CNA, were the only three (3) staff on the schedule, all three (3) lacked documentation of First Aid Certification.</p> <p>On 2/12/14 night shift 11:00 p.m.-7:00 a.m., Employee #24-LPN, Employee #22-CNA, were only two (2) staff on the schedule, both lacked documentation of First Aid Certification.</p> <p>On 2/18/14 night shift 11:00 p.m.-7:00 a.m., Employee #24-LPN, Employee #22-CNA, Employee #23-QMA, were only three (3) staff on the schedule, all three (3) lacked documentation of First Aid Certification.</p> <p>On 2/19/14 night shift 11:00 p.m.-7:00 a.m., Employee #24-LPN, Employee #25-CNA, Employee #23-QMA, were only three (3) staff on the schedule, all three (3) lacked documentation of First Aid Certification.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 3021 STELLA DRIVE GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>On 2/15/14 day shift 7:00 a.m.-3:00 p.m., Employee #14-LPN, Employee #11-CNA, Employee #13-CNA, Employee #12-CNA, were only four (4) staff on the schedule, all four (4) lacked documentation of First Aid Certification.</p> <p>On 2/16/14 day shift 7:00 a.m.-3:00 p.m., Employee #14-LPN, Employee #13-CNA, were only two (2) staff on the schedule, both lacked documentation of First Aid Certification.</p> <p>The Resident Nursing Coordinator acknowledged during interview on 2/20/14 at 12:45 p.m., there were some shifts mainly nights and a couple on days that had no First Aid Certified employees scheduled/or worked. The following dates 2/9/14, 2/11/14, 2/12/14, 2/18/14, and 2/19/14, a staff person with First Aid Certification was not scheduled to be on-site for the night shift and on 2/15/14 and 2/16/14 for the day shift. Upon request documentation for First Aid Certification was not provided for CNA #12, 13, and 22, QMA #23, and LPN #14 and #24 and additionally for CNA #15 and #25.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 3021 STELLA DRIVE GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure a clinical record was maintained with complete and pertinent information for 1 of 6 resident records reviewed. (Resident #19)</p> <p>Findings include:</p> <p>The clinical record of Resident #19 was reviewed on 2/19/14 at 11:30 a.m. Diagnoses for Resident #19 included, but were not limited to, dementia, atrial fibrillation, diabetes, and angina (chest pain).</p> <p>A physician's order, dated 12/10/14, indicated Resident #19 was to receive an electrocardiogram (EKG) (a recording of the electrical activity of the heart) and a HgA1C (a blood</p>	R000349	<p>R 349 Clinical Records – Noncompliance Corrective Action Taken: Potential Residents Affected: Measures to Ensure does not Recur: · Staff trained to flag resident change in condition/needs in the Communication Book, referring to the resident's chart for documentation of that change. · Divisional Director of Resident Services to review proper protocol and clinical practice for documentation of physicians' orders and phone calls to healthcare professionals with RNC. · Divisional Director of Resident Services will complete random check of charts for new physician's orders and ensure appropriation documentation of this process on site visits monthly. Monitor performance to ensure compliance as follows:</p>		03/07/2014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/20/2014	
NAME OF PROVIDER OR SUPPLIER BICKFORD OF GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 3021 STELLA DRIVE GREENWOOD, IN 46143			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>test which measures the average glucose levels in the blood over 6-8 week period). This physician's order indicated the EKG was ordered to rule out chest pain. No results for these tests were found in the resident's record. Further information regarding these results was requested from the R.N. Coordinator on 2/19/14 at 1:00 p.m.</p> <p>On 2/19 at 4:00 p.m., the R.N. Coordinator indicated she remembered notifying Resident #19's daughter of the above new orders and the daughter did not want these tests done on the resident. The R.N. Coordinator indicated, at that time, she should have notified the physician and documented this information in the resident's record.</p> <p>On 2/19/14 at 4:00 p.m., the R.N. Coordinator provided a physician's order, written on 2/19/14, to discontinue the orders for the EKG and the HgA1C.</p>		<p>Date of Compliance: 3/7/2014 Divisional Director of Resident Services to audit residents' charts checking for congruency between resident's needs for care, the change in resident's condition, contacts with their healthcare provider, any new orders obtained and the documentation of that process at least twice a year using QA Audit (Core Check) tool. No resident was negatively affected by the deficient practice. The RNC has reviewed and audited all resident charts to ensure that all physician's orders have been documented and carried out per policy.</p>				